

# Clinical Issues In Working With Lesbian, Gay, and Bisexual Clients

John E. Pachankis and Marvin R. Goldfried  
State University of New York at Stony Brook

This article discusses some of the key clinical issues for therapists to consider when working with lesbian, gay, and bisexual (LGB) clients. After a discussion of the biases that can influence psychotherapy, guidelines are given for conducting LGB-affirmative therapy that avoids these biases. Issues that therapists need to be familiar with in working with LGB clients include LGB identity development; couple relationships and parenting; LGB individuals as members of families; the unique stressors faced by individuals who are underrepresented in the LGB research literature (e.g., older LGB individuals, ethnic minorities, religious LGB individuals, bisexual individuals); and legal and workplace issues. An examination of the published literature is offered with particular emphasis given to the available empirical research.

Lesbian, gay, and bisexual (LGB) women and men utilize therapy at rates higher than the general population (Bell & Weinberg, 1978; Liddle, 1996; Morgan, 1992; National Lesbian and Gay Health Foundation, 1988), and nearly all therapists report seeing at least one LGB client in their practices (Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991). Yet, the mental health professions have historically demonstrated heterocentric and homophobic beliefs, prejudices, and practices against LGB individuals, placing the burden of distress on the client and his or her possession of an illness (Goldfried, 2001). Indeed, some professionals continue to promote cures for homosexuality (Nicolosi & Nicolosi, 2002). Even when homosexuality is not viewed as pathological, mental health professionals need to consider the distress that antihomosexual bias can cause LGB individuals. Disregarding such factors may lead to erroneous and unfortunate attributions of the sources of distress in an LGB person who is seeking therapy.

There is a dearth of systematic research on the unique therapy experiences of LGB individuals. Although theoretical work on the nature, etiology, and consequences of LGB identities abounds, little exists in the way of empirical studies on these issues. Thus, it comes as no surprise that when working with LGB clients, we as therapists are often inadequately equipped in our training to handle issues that are unique to LGB individuals (Phillips & Fischer, 1998). As a consequence, LGB clients have a right not only to be skeptical of our competence in handling their LGB-related issues but also to expect that we gain proficiency in handling any such issues that may arise in the therapeutic context.

Although guidelines for conducting psychotherapy with LGB clients exist (American Psychological Association, 2000), there is

a need for work that explicates these guidelines with the intent of making them more useful for clinicians. Important issues in the lives of LGB clients include LGB identity development, romantic relationships, family relationships, and parenting. There are a number of additional issues and considerations that are important to consider when working with certain members of this population (e.g., specific issues of concern to bisexual, ethnic minority, and older LGB individuals).

The primary purpose of this article is to provide an overview of many of the issues we need to know about as therapists when working with LGB clients. As will be seen, some of these issues are based on clinical impressions and some on research findings. We first consider the ways that heterocentrism and homophobia affect LGB individuals and some of the potential therapeutic biases that may arise when working with LGB clients. Toward the goal of encouraging an LGB-affirmative approach to therapy, several of the specific issues confronting our LGB clients are then discussed.

## Homophobia and Heterocentrism

It is important for us to understand the antihomosexual biases that can operate in both obvious and subtle ways in society. These biases may not only influence our conceptualizations of our clients but can also influence our LGB clients' conceptualizations of themselves.

*Homophobia* is the term typically used to describe hostility and prejudice toward homosexual individuals and their behavior (Herek, 1996a). Homophobia refers to an extreme, negative reaction on the part of both heterosexual and homosexual persons to homosexual individuals and homosexual behavior. The term homophobia, however, has been criticized by some as inaccurate and misleading because of the fact that it is not a phobia in a clinical sense (Kitzinger, 1987; Shields & Harriman, 1984), even though the reactions of some individuals may indeed best be conceptualized as phobic in nature. In addition, Herek (1991) objected to the use of the term homophobia because it suggests a pathology in the person who displays it instead of an internalization of cultural values.

---

John E. Pachankis and Marvin R. Goldfried, Department of Psychology, State University of New York at Stony Brook.

We thank Catherine Eubanks-Carter and Anita P. Goldfried for their helpful comments on an earlier version of this article.

Correspondence regarding this article should be addressed to John E. Pachankis, Department of Psychology, State University of New York, Stony Brook, NY 11794-2500. E-mail: john.pachankis@sunysb.edu

This article is reprinted from *Psychotherapy Theory, Research, Practice, Training*, 2004, Vol. 41, No. 3, 227–246.

Our society often assumes that the experiences of middle-class White men generalize to all individuals. As a result, the unique perspectives and experiences of non-White, nonmale individuals often get overlooked. Similar biases occur against a range of diverse groups, including racial minority, non-Christian, economically disadvantaged, older, or LGB individuals. We choose the term *heterocentrism* to describe this implicit—and at times explicit—bias against LGB individuals. The term *heterosexism* is the term typically used in the literature to describe such bias. Yet, the term *heterocentrism* better captures the notion that this bias is often not intentional but is rather due to oversights on the part of mainstream society in considering the existence of diverse sexual orientations. Heterocentrism manifests itself in more subtle ways than does homophobia. Heterocentrism is conveyed by the systemic attitudes and assumptions that operate in a society that understands itself, by default, as purely heterosexual. Heterocentric beliefs, according to Herek (1996a), are manifested at both cultural and individual levels. At the cultural level, heterocentrism is evident in the laws, bans, and lack of recognition of LGB individuals that serve to restrict the rights and opportunities of LGB individuals. This societal heterocentrism is manifested at an individual level when a person internalizes the hostility and disdain that society exhibits toward LGB individuals and their behaviors.

Children are exposed to these societal notions at an early age. Thus, upon recognizing a possible LGB identity within themselves, LGB individuals may naturally feel ashamed and compelled to hide. In fact, it has been observed that LGB adolescents become quite adept at learning to hide (Martin, 1982; Radkowski & Siegal, 1997). This manifestation of shame is referred to as “internalized homophobia.” Individuals seldom come to therapy stating that they are “internally homophobic” (Margolies, Becker, & Jackson-Brewer, 1987). Instead, as some have proposed, such feelings may manifest themselves in anxiety and depression (Matthews, Hughes, Johnson, Razzano, & Cassidy, 2002), relationship difficulties (Green & Mitchell, 2002), substance abuse (Hughes & Eliason, 2002), suicide (Safren & Heimberg, 1999), and the devaluation of LGB activities (Stein & Cabaj, 1996). Still, it seems that most sexual minority individuals are able to establish a positive identity in spite of the threats posed by internalized homophobia and societal heterocentrism. Such psychological adjustment in the face of heterocentrism and internalized homophobia is probably mediated by the degree to which an LGB individual is committed to his or her LGB identity; the level of his or her contact with other LGB individuals; the amount of family support that he or she receives; and the extent to which an LGB individual is open about his or her sexual identity. However, even with the aid of these buffers, it is unlikely that LGB individuals can entirely escape the effects of internalized homophobia.

LGB individuals who hide their sexual identity experience a discrepancy between their true selves and the selves that they present to others. These individuals may feel inauthentic, as if they are living a lie. They may also feel that if others knew their true sexual identity, they would be rejected (Herek, 1996b). These individuals are likely to avoid social situations, especially those in which they feel their sexual identity will be called into question.

It is important for us as therapists to recognize that an LGB client's problems are not necessarily intrinsic to his or her sexual orientation. Instead, in working with LGB individuals, we need to

understand that LGB clients' problems may arise as the result of society's negative reaction to nonheterosexual orientations. It is thus important for us to be aware of the effects that societal factors can have on LGB individuals' psychological well-being and identity development.

### Potential Therapeutic Biases

As suggested above, societal and individual heterocentrism can affect the ways we conceptualize and treat our clients. Countering such bias is central to establishing ethical practices with LGB clients (Brown, 1996). There are many obvious and subtle biases that can permeate the treatment of an LGB individual. In a survey of a diverse sample of psychologists, the APA Task Force on Bias in Psychotherapy With Lesbians and Gay Men found a variety of accounts of biased treatment of LGB clients (Garnets et al., 1991). One of the most blatant injustices that the Task Force mentioned is the attempt by a therapist to change the client's sexual orientation or to make continuation in therapy contingent on “dealing with” one's LGB identity. Further abuses include therapists attributing a client's problems to his or her sexual orientation without taking into account the damage that societal heterocentrism and internalized homophobia can inflict on LGB individuals. Less than appropriate treatment of LGB clients also occurs when either (a) a therapist assumes that the client is heterosexual or (b) when an LGB orientation is revealed, the therapist then focuses on the sexual orientation of the client despite the fact that this is not an issue at hand. Other mistreatment occurs when a therapist is unaware of the unique aspects inherent in LGB identity development; how LGB individuals deal with family of origin issues; the parameters associated with LGB romantic relationships and LGB individuals as parents; and the unique issues experienced by older LGB individuals, religious LGB individuals, and ethnic minority LGB individuals. Such inadvertent biased practices may cause distress for an LGB client at a time when the client is in need of empathetic care.

Given these very real risks of biased treatment, it is essential to investigate the possibility that therapists' original training and continued education fail to facilitate competence in working with LGB clients. It has been suggested that the most powerful sources of biased treatment of LGB clients include biased training, lack of contact with LGB individuals, and fear or denial of same-sex feelings or feelings toward LGB orientations (Morrow, 2000). Despite the profession's official stance toward LGB issues, evident in its guidelines and policies (APA, 1997, 2000), psychology has a history of misunderstanding individuals who are sexual minorities. It is, therefore, not surprising that past surveys have found less-than-ethical practices by psychologists working with individuals from sexual minority groups.

As psychotherapists, we have been trained in a heterocentric society in a historically heterocentric profession. Most graduate training programs provide minimal training on the unique issues that LGB individuals present in therapy, and few professionals pursue appropriate continuing education that focuses on such issues (Anhalt, Morris, Scotti, & Cohen, 2003; Phillips & Fischer, 1998). Such gaps in knowledge leave us with no alternative but to draw from the societal and personal biases that we possess. Gelso, Fassinger, Gomez, and Latts (1995) and Hayes and Gelso (1993) examined therapists' reactions to lesbian, gay, and heterosexual

clients in analogue studies and found that therapists' homophobia was positively correlated with their avoidance of gay and lesbian-related material concerning relationship issues or sexual difficulties. However, it should be noted that as a group, counselors did not exhibit greater avoidance or anxiety with lesbian or gay clients than they did with heterosexual clients. Yet, the findings indicate that when even a moderate level of therapist homophobia exists, it may impede interventions with lesbian and gay clients. The authors recommend that when such levels of homophobia are present, therapists should seek assistance from an experienced, gay-affirmative supervisor.

Such biases may result from inadequate experience with LGB individuals in the therapist's personal life. It has been found that people who have had direct contact with at least one LGB individual report more favorable attitudes about persons with an LGB identity (Herek & Capitanio, 1996). Thus, it is important for us as therapists to consider increasing our personal contact with LGB individuals in order to disabuse ourselves of unchallenged assumptions about LGB individuals and behavior. Furthermore, in order to counter our fear or denial of having same-sex feelings, it is essential for us to explore our personal thoughts, feelings, attitudes, beliefs, and values about nonheterosexual orientations. Morrow (2000) suggested that therapists examine their own sexual orientation, what this sexual orientation means to their identity, and how their sexual orientation might influence their conceptualization and treatment of LGB individuals in therapy.

It is important for therapists with an LGB identity to note that they are not immune from implementing biases in their work with LGB clients. Indeed, they, too, should examine what their sexual identity means to them and how it may influence their treatment of both heterosexual and sexual minority clients. For example, an LGB therapist may have little tolerance for the internalized shame that keeps clients from coming out and may push them to come out before considering their unique circumstances. LGB therapists must also deal with the consequences of possible overlap between their personal and professional lives. LGB women and men often travel in small social circles as a result of limited LGB-related resources, activities, and venues. This is particularly common in smaller cities and rural areas, where LGB therapists may live and work within the same social circles as their LGB clients. Therapists encountering such role overlap must caution against breaches of client confidentiality and other boundary violations (Brown, 2000; Gartrell, 1994; Shannon & Woods, 1991). It is important for LGB therapists to have a strong social support network so that their exposure to LGB individuals does not solely consist of contact with their LGB clients. Additionally, Brown (1989) suggested that LGB therapists who are in the process of discovering their LGB sexual orientation should wait at least 2 years after accepting an LGB identity before working with LGB clients so as to avoid problematic countertransference and vicariously experiencing coming out issues through their LGB clients.

### LGB-Affirmative Therapy

To meet the need for empathetic, nonbiased psychological treatment for LGB individuals, some therapists have developed models of therapy that affirm LGB identities and seek to foster the development of all aspects of an LGB client's identity and the enhancement of an LGB individual's experiences. Still, many clinicians

think that LGB clients can and ought to be treated in the same manner as their heterosexual counterparts. Despite such good intentions, it is essential to recognize that LGB clients present unique issues in the therapeutic context. LGB-affirmative therapists utilize the body of knowledge that addresses issues specific to LGB individuals with the purpose of bridging the gaps left by the heterocentric assumptions of the prevailing therapy models (Davies & Neal, 1996). Some psychologists conceptualize affirmative therapy as an adaptation of prevailing models of therapy to the specific issues related to LGB individuals. For example, some state that because basic cognitive-behavioral principles apply to working with LGB clients, the addition of LGB considerations to the framework of cognitive-behavioral therapy is sufficient for LGB-affirmative therapists (e.g., Purcell, Campos, & Perilla, 1996; Safren & Rogers, 2001; Clark, 1987; Davies, 1996; Isay, 1989).

To our knowledge, no studies have examined the effectiveness of particular theoretical orientations in working with LGB clients. Some professionals suggest that a variety of theoretical orientations can be effective in working with LGB clients as long as the therapist operates from an affirmative stance (Cornett, 1993; Dworkin, 2000; Falco, 1991, 1996; Fassinger, 1991, 2000). Regardless of how one integrates affirmative practices into his or her own work with LGB clients, it is important to operate from such a stance by considering the core tenets of LGB-affirmative therapy that are relevant to the case at hand. These core principles are described below.

A number of clinicians have offered guidelines for implementing affirmative therapy. Among them, Clark (1987) proposed specific tasks that each therapist-client dyad ought to address. These include encouraging LGB clients to establish a support system of other LGB individuals; helping clients become aware of how oppression has affected them; desensitizing the shame and guilt surrounding homosexual thoughts, behaviors, and feelings; and allowing clients' expression of anger in response to being oppressed. To carry out these tasks, we as therapists must first examine our feelings and attitudes toward LGB individuals and behavior and, as a result, feel competent to work with them. Davies (1996) suggested that therapists need to amplify Rogers' (1951) core provision of unconditional positive regard in working with LGB clients. This includes explicitly showing respect for the client's sexual orientation, personal integrity, lifestyle, attitudes, and beliefs.

Shannon and Woods (1991) suggested that therapists of LGB individuals must act as advocates for their LGB clients by helping them to face the challenges inherent in possessing a sexual minority status. They state that therapists should help the client identify those societal issues that the client feels compelled to challenge and should support him or her in that action, as well as teach coping skills for those issues that cannot be successfully challenged at this particular point in history. Additionally, LGB-affirmative therapists need to be aware of the resources available for LGB clients. Such resources include gay-straight alliances in junior and senior high schools and on most college campuses; religious groups, such as LGB synagogues within the Jewish Reform Movement and the network of Roman Catholic LGB individuals, Dignity/USA; groups that offer contact and networking opportunities within professions, such as the National Gay Pilots Association; LGB reading groups; and a wide variety of organizations for ethnic and racial minority LGB individuals.

LGB-affirmative therapists acknowledge that some of the mental health problems of LGB individuals are not necessarily a result of one's LGB status per se but rather can be a reaction to society's response to LGB individuals and their behaviors. Clearly, LGB clients may possess certain pathologies that are not the result of their sexual orientation or society's reaction to it. When working with our LGB clients, we therefore need to ask ourselves whether the focus should be on the presenting disorder or issues concerning the client's sexual orientation. When we conceptualize our approaches to LGB clients by considering such fundamental issues, we pave an affirmative path to intervention.

### LGB-Specific Issues

Some of the key issues that we as therapists need to understand in order to provide effective treatment to our LGB clients include identity development, intimate relationships and parenting, family issues, the unique experiences of underrepresented sexual minority populations (e.g., ethnic minority, religious, older, and bisexual individuals), and legal and workplace issues.

### Identity Development

One of the most widely addressed issues in the LGB psychological literature is that of LGB identity formation among adolescents and young adults (D'Augelli & Patterson, 2001). This literature primarily focuses on the processes by which an individual acquires an LGB identity and the additional lifelong efforts required to establish and maintain an identity that is positive. This process of identity formation is commonly referred to as "coming out." As discussed earlier, many young LGB individuals encounter enormous hardship in the face of societal homophobia and heterocentrism, their own internalized homophobia, coming out to themselves and others, and a lack of competent and respected role models. A study of harassment in general among high school students found that the most upsetting form of harassment was to be called "gay" (American Association of University Women, 1993). The effects of such perceptions of the hatred and ridicule of LGB identities may be particularly poignant for LGB youth who are beginning to suspect that they may possess a nonheterosexual identity. These individuals may become the victims of verbal, physical, and sexual harassment (Comstock, 1991; D'Augelli, 1992; Herek, Cogan, & Gillis, 2002).

Summarizing data from the 1970s and 1980s, Garnets and Kimmel (1993) found that on average, gay males begin to suspect that they might be homosexual between the ages of 12 and 13 and that this occurs for lesbian individuals between the ages of 14 to 16. However, it is important to consider a possible cohort effect for these findings. Gay men and lesbian women may be influenced by society's growing tolerance of sexual minorities in such a way that the average age of coming out may be somewhat different now than it was at the time of earlier studies. Such cohort effects are briefly noted in the concluding section of this article. Still, therapists working with children and families should be aware that LGB individuals—especially preadolescent boys—possess an awareness of "being different" that often emerges much earlier than the age at which they suspect that they may be LGB. Further, LGB individuals are often aware of their same-sex attractions for a few years before they label themselves as LGB.

Because most LGB individuals are reared by heterosexual parents and because most LGB adults in youngsters' lives (e.g., educators, coaches, scout leaders) are discouraged from revealing their sexual orientations to young people, LGB youth commonly discover their differences in isolation. It has been suggested that this isolation often leads to feelings of being sick, sinful, deviant, invisible, and defective (Herd, 1989). Such feelings may, in turn, give rise to anxiety and depression. D'Augelli and Hershberger (1993) found that 63% of their adolescent LGB sample who attended community LGB programs were so worried or nervous in the past year that they could not function, and 73% said that they were depressed at the time of the study. Still, there are a number of ways in which therapists can make the lifelong process of incorporating one's LGB identity into an overall healthy personal identity easier for LGB clients.

When working with young LGB individuals, it is necessary to take into account the developmental status of the individual both in terms of the traditional life span trajectory and also in terms of where the client falls in terms of his or her LGB identity development. As therapists, we need to acquaint ourselves with the prevailing models of LGB identity development (e.g., Cass, 1979; Coleman, 1981/1982; Grace, 1992; Troiden, 1979). Although the developmental stages of typical LGB individuals are largely similar across models, it is important to realize that many developmental pathways lead to the same sexual orientation (Savin-Williams, 2001).

In their comprehensive volume addressing the needs of LGB individuals in therapy, Ritter and Terndrup (2002) offered a general outline of the stages of LGB identity formation. They noted that most LGB identity development models begin with a stage commonly labeled "sensitization" or "pre-coming out." This stage focuses on the general feelings before puberty of marginality and difference from same-sex peers (Troiden, 1979). In one study, gay men and lesbian women were nearly two times as likely to report feelings of being "very much or somewhat" different from their same-sex peers (Bell, Weinberg, & Hammersmith, 1981). This difference is mostly reported in terms of nonconformity to the gender roles stipulated by society (Bailey, Nothnagel, & Wolfe, 1995; Dunne, Bailey, Kirk, & Martin, 2000; Phillips & Over, 1992; Troiden, 1993).

During adolescence, however, childhood feelings of difference may become associated with perceptions of oneself as *sexually* different. Because of their socialization in a heterocentric society and the subsequent isolation and accompanying feelings described above, it is likely that adolescents experience such difference as unacceptable, often resulting in psychological and behavioral difficulties during this stage of the coming-out process (Ritter & Terndrup, 2002). It has been observed that such manifestations may include one or more defensive strategies, such as seeking reparative therapy to eliminate homosexual feelings; assuming an antihomosexual stance; controlling information about oneself; escaping through substance abuse; indicating that one is just passing through a phase; immersing oneself in a heterosexual identity (e.g., getting married to an opposite-sex partner); defining situations rather than sexual orientation as the cause of homosexual feelings or activities ("I only had sex with him because I was drunk"); compensating for perceived defectiveness by devoting enormous energy to career or academic success; and crusading against LGB causes and individuals (Cass, 1979; Ritter & Terndrup, 2002; Stein



& Cabaj, 1996; Troiden, 1979). In coming out, individuals can display any range of negative psychological symptoms, especially if there is a lack of support during the process (Frable, Wortman, & Joseph, 1997). It has been suggested that the best predictor of adjustment to one's LGB identity, however, is the client's functioning prior to coming out rather than the presenting symptomatology (Gonsiorek & Rudolph, 1991).

In most models, Ritter and Terndrup (2002) noted, the next stage of identity formation typically involves *toleration* of an LGB identity. Individuals at this stage may still not reveal their LGB identity but may instead engage in double lives—one LGB, the other heterosexual. While the LGB individual is concealing his or her LGB identity from family members and friends, the individual's growing tolerance of his or her LGB identity allows him or her to begin to seek out other LGB individuals and communities in order to fulfill emotional, social, and sexual needs. According to these models, after an individual learns that such contact with other LGB people is rewarding, he or she eventually comes to accept his or her LGB identity and attempts to reduce the discordance that comes from a "dual" life. The LGB individual may demonstrate pride in his or her LGB identity as he or she seeks out further social contacts, including intimate same-sex relationships with other LGB individuals. Whereas reactions in earlier stages defended against homosexuality, it has been clinically observed that reactions in this stage may include overidentifying with a homosexual identity, distrusting heterosexual individuals, and challenging heterosexual individuals with extreme manifestations of stereotypically homosexual behavior (e.g., gay men behaving in a stereotypically feminine manner in order to elicit a reaction from heterosexual onlookers). A successful outcome of the coming-out process will likely involve the integration of one's LGB identity into one's overall sense of self.

Although these models are helpful, as therapists, we should bear in mind that LGB individuals experience the coming-out process and pacing of coming out in unique ways, and, consequently, we should not have specific expectations in mind for our LGB clients. In particular, coming out may be more flexible for lesbian and bisexual women because of more flexible gender roles for women overall in society (Gonsiorek, 1988). Further, Diamond's (1998, 2000, 2003) findings regarding the fluidity of sexual identity, attraction, and behavior support the criticisms that many women, in particular, have levied against the linearity of coming-out models.

In discussing psychotherapeutic applications of the stage models, Ritter and Terndrup (2002) recommended, "To facilitate identity formation in LGB clients, therapists must meet them at their level of development and intervene appropriately" (p. 169). They and others (e.g., Hershberger & D'Augelli, 2000) have suggested a number of interventions for each stage of identity development, a few of which are discussed here.

Clients in the earlier stages of coming out may express internalized homophobia in association with a range of issues related to their marginalized sexual identity. In such cases, it may be important for us to validate our clients' feelings with the goal of helping them accept such feelings as natural and appropriate (Radkowski & Siegal, 1997). In doing so, we lay the groundwork for a positive corrective experience in which the client as an LGB individual is genuinely accepted.

It has been clinically observed that the more firm an LGB youth's family and peer support network is, the more apt he or she is to survive rejection and develop a more self-accepting identity (Anderson, 1987). However, we may have to assist an LGB client in weighing the costs and benefits of coming out to others. In some instances, the client may need to understand that, despite the excitement of his or her new identity, it would be better to delay disclosure of this information until greater control over its consequences can be managed (e.g., once she or he is no longer financially dependent on parents). There is the danger of equating openness about sexual orientation with psychological health, which can result in clients coming out in potentially hostile environments. It therefore seems judicious to encourage clients to "test the waters" by first disclosing their sexual orientation to individuals who are likely to be supportive.

Many LGB individuals lag behind their peers with respect to social development for reasons attributable to societal constraints on sexual minorities and the extra time often required for LGB individuals to establish an LGB identity. For instance, LGB individuals often do not have a chance to establish dating relationships until later ages than their heterosexual peers (Diamond, 2003). As a result, they may lack the appropriate skills necessary to succeed in many of their relationships. Such clients may benefit from cultivation of interpersonal skills such as assertiveness (Ritter & Terndrup, 2002).

In the final stages of identity development, clients may benefit from a discussion of the consequences of isolation in a predominantly gay or lesbian community. We might also help clients explore differences as well as similarities between themselves and the lesbian and gay subculture. In facilitating our clients' reintegration into the dominant culture, we increase the likelihood that they will encounter corrective experiences with heterosexual individuals. When relevant, we might help our LGB clients understand their past as a course often characterized by victimization and stigmatization in hopes of eradicating the self-blame that may have resulted from these marginalizing experiences (Ritter & Terndrup, 2002).

## Couple Relationships and Parenting

In many respects, LGB couples are much like their heterosexual counterparts. However, because of homophobia, the heterocentric standard that exists in our society and the additive effects of gender-role socialization that occur in same-gender dyads, the experiences of LGB couples can differ substantially from heterosexual couples. There is some preliminary evidence that LGB couples function at least as well as heterosexual couples. Specifically, it has been suggested that LGB couples are at least as cohesive, flexible, and equal in terms of gender roles and at least as satisfied with their relationships as heterosexual couples (Green, Bettinger, & Zacks, 1996). It has been found that satisfaction and stability in gay and lesbian relationships are related to similar emotional qualities as those that operate in heterosexual relationships (Gottman et al., 2003; Kurdek, 1992). Still, because of societal oppression, LGB couples may face many challenges that heterosexual couples do not.

The notion of fusion in lesbian couples and disengagement in gay male couples has received popular support. However, these ideas are somewhat problematic for at least two reasons: (a) they

treat lesbian and gay couples as pathological and (b) the observations that support these views seem to be derived by clinicians who use their clients as representatives of all lesbian and gay couples (Green & Mitchell, 2002). Indeed, it has been found that fusion in lesbian couples may represent a positive component of interpersonal relatedness and may foster the trust and safety needed for personal growth for partners within the relationship (Burch, 1986). Moreover, it may be the case that gay male couples are actually more cohesive than heterosexual couples, not more disengaged (Green et al., 1996).

The stereotype of gay men as purely sex-driven and nonmonogamous has also been challenged by research. Peplau (1991) reported that between 40 and 60% of gay men were in a steady relationship at the time of her study. This is probably an underestimate given that this research was conducted in social settings such as bars. One result of many gay men's nonconformity to traditional masculine roles is that their greater expressiveness and interpersonal orientation may lead them to be less likely to emotionally distance themselves in intimate relationships. Some gay male couples, however, may have grown ashamed of their sensitivity and emotional expressiveness, owing to ridicule earlier in life. In such cases, we as therapists may need to devote substantial energy to rekindling these positive attributes in our clients (Greenan & Tunnell, 2003). While it is true that gay men in relationships have been found to be less monogamous than other individuals (Bell & Weinberg, 1978), we need to understand the meaning and implications that sex often has for gay men. Like heterosexual men, many gay men in relationships do not seem to attach emotional meaning to the sex that they have with others outside of their primary relationship (Blumstein & Schwartz, 1983; Peplau & Cochran, 1981). Kurdek (1988) found that the personal quality of the relationships of the gay cohabiting couples in his study who had sex outside of their primary relationship did not suffer. It is important for us as therapists to consider the unique issues that arise when two individuals of the same gender are involved in a romantic relationship.

Unlike many heterosexual couples, lesbian and gay couples might have to work extra hard in negotiating the meaning, significance, and function of their relationship. This is likely due to the heterocentric institutions in society that typically deny lesbian and gay relationships the legal, familial, and social recognition that their heterosexual counterparts receive. This can lead to unexpected beneficial outcomes, such as greater role equality, given that individuals in same-sex couples must decide the form that their relationship will take instead of simply following heterosexual models. However, this may also create problems such as ambiguity about the parameters of the relationship with respect to financial and living arrangements (Green & Mitchell, 2002; Greenan & Tunnell, 2003). For lesbian and gay couples not united by the societal construct of "marriage," moving in together may serve the same function that marriage does for heterosexual couples. Still, the question has been raised as to whether or not living together represents a lifelong commitment in the same way that marriage does (Green & Mitchell, 2002).

We as therapists may also be confronted with the unique concerns of LGB individuals who are involved in opposite-sex relationships. Little research has been conducted on the topic of LGB individuals in heterosexual marriages, probably because of the invisibility of such marriages and the reluctance of sexual minority

spouses to identify themselves as LGB. Despite this research gap, a few studies are informative.

Higgins (2002) examined the experiences of gay or bisexual men married to heterosexual women. He found that the two most frequent reasons that men provided for entering a heterosexual marriage were that it seemed natural and that there was a desire for a "traditional" family. Higgins suggested that internalized homophobia may in fact explain the existence of such marriages, whereas cognitive dissonance may explain their eventual breakup. Yarhouse, Pawlowski, and Tan (2003), alternatively, used qualitative methodology to examine opposite-sex couples in which both parties reported satisfaction with the arrangement, despite the fact that one identified as nonheterosexual. Results from this study revealed that the couples' religious faith and the degree to which they espoused similar worldviews fostered satisfaction with their marriages.

Buxton (2001) reported the experiences of bisexual husbands and their heterosexual wives. She found that honesty, open communication, peer support, and therapy were helpful for many of the couples in her sample. Matteson (1985) found that bisexual men who disclosed their bisexual orientation to their wives were better able to develop a positive sexual identity than men who had not disclosed. Thus, we have preliminary support for the possible importance of honesty on the part of the LGB partners in opposite-sex relationships regarding their sexual orientation. It may be important to help our LGB clients in heterosexual relationships consider the impact of such honesty on their relationships.

The presence of children in families in which at least one partner is LGB raises additional issues to consider. In our clinical work with lesbian and gay parents, we need to be prepared for a number of unique issues that may arise (Bigner, 1996). Most of the research on sexual minority individuals as parents was primarily conducted to establish the legitimacy of lesbian and gay parents, specifically for forensic purposes. Such research is over a decade old and mostly focuses on financially privileged, White, well-educated lesbian mothers. Probably because most bisexual individuals with children are parents within a heterosexual relationship, no research that we know of has examined bisexual parenting. Descriptive research has shown that gay men and lesbian women become parents through a variety of means, such as previous heterosexual relationships, adoption, surrogacy for gay men or, for lesbian women, artificial insemination from known and anonymous donors (Johnson & O'Connor, 2001).

Research has shown that children with one or more lesbian or gay parents are similar to their peers raised by two heterosexual parents in terms of psychological, behavioral, emotional, and intellectual functioning (Fitzgerald, 1999). Children with homosexual parents have been found to be no different from children of heterosexual parents in terms of gender identity (Green, Mandel, Hotvedt, Gray, & Smith, 1986; Kirkpatrick, Smith, & Roy, 1981), gender-role behavior (Green, 1978; Kirkpatrick et al., 1981), and sexual orientation (Green, 1978). The research in this area provides no reason for denying rights to lesbian and gay parents on the basis of their sexual orientation (Patterson, 1995).

Lesbian and gay clients may need help in coming out to their children and, if married, spouses. As with all LGB individuals in therapy, regardless of parenting status, clients often need help resolving their conflicts with internalized homophobia and heterocentrism. Indeed, for some lesbian and gay parents who have

children from a heterosexual marriage, such internalized homophobia may have contributed to their being in such a relationship and having children (Higgins, 2002). In helping our clients develop a positive identity as a gay or lesbian parent, it is important for us to encourage them to establish social connections with other same-sex parents. Therapists may wish to recommend books targeting the issues involved in LGB parenting; Johnson and O'Connor (2001, 2002) have written two particularly useful guides for lesbian and gay parents. The formation of a stepfamily within a homosexual parenting relationship may also create unique issues for clients. Therapists working with these clients should be familiar with the legal issues surrounding LGB parenting and help the client consider these when relevant. For instance, therapists working with clients undergoing custody battles or dealing with visitation issues may need to help them face court decisions unfairly made on the basis of the clients' sexual orientation.

### Families of Origin and Families of Choice

The popular image of LGB individuals seldom portrays them as members of families. Indeed, LGB individuals have been viewed by some segments of society as antifamily (Goldfried & Goldfried, 2001; Strommen, 1993). When LGB individuals are portrayed as members of families both in research and in popular culture, the image is often one of an LGB individual estranged from his or her family of origin (Laird, 1998).

It has been observed that families typically react negatively at first to their LGB relatives' revelation and only become more accepting over time (Savin-Williams, 2001). Further, it is often said that when LGB individuals come out of the closet, the family members go in (Strommen, 1993). Family members need time to work through their own feelings, attitudes, and beliefs surrounding sexual orientation. The organization PFLAG (Parents, Families, and Friends of Lesbians and Gays) has local chapters across the country to offer support to LGB individuals and their families who are experiencing such issues. A referral to PFLAG ([www.pflag.org](http://www.pflag.org)) is often the intervention of choice in such situations (Goldfried & Goldfried, 2001).

Most LGB individuals are raised by heterosexual families. Yet, there is little empirical research on the experiences of heterosexual family members of LGB individuals. Crosbie-Burnett, Foster, Murray, and Bowen (1996) suggested that the lack of research attention given to heterosexual family members is "a reflection of their near invisibility, closeted status, and marginalization in the society in general" (p. 397). Thus, Crosbie-Burnett et al. offered a theory to serve as a guiding framework for more research in this area. In their work, they discussed the fact that upon an LGB relative's disclosure of his or her sexual orientation, heterosexual family members may have to negotiate a schema shift. They offered the example of such a shift from "I am a father in a typical American family" to "I am a father in a family with a gay son" (p. 399).

Clients should be prepared to accept their families' own coming-out process. As the coming out process for LGB individuals can often be a long, arduous journey, so too can be the comingout process for family members. Clients ought to be reminded that just because family members may not *currently* accept their LGB identity does not mean that they will not *eventually* come to terms with it (Matthews & Lease, 2000). Upon learning of

an LGB relative's sexual orientation, families must often renegotiate their relationship with their LGB relative and her or his embodiment of the family's (often negative) perception of homosexuality (Mattison & McWhirter, 1995). This process is akin to viewing a movie at the end of which a critical piece of information is revealed. Viewers must then replay the movie in their head to make sense of the previous plot in light of this new information. Indeed, this new information may cause previous events to be interpreted in an entirely new light. Dahlheimer and Feigal (1994) suggested that family members' reactions to an LGB relative's disclosure are often similar to the stages-of-grief model proposed by Kübler-Ross (1969): denial, anger, guilt, acceptance, and hope. During the initial stages of this process, family members often invest much time in trying to figure out why their relative is LGB, possibly looking for some person or childhood event to blame. Further, if family members of an LGB relative decide to "come out" about their loved one, they may have to deal with the same homophobia and heterocentrism that LGB individuals face (Crosbie-Burnett et al., 1996). Goldfried and Goldfried (2001) offered a personal account of coming out as the parents of a gay son and the establishment of a group of psychologists uniting in support of their LGB relatives. This group—AFFIRM: Psychologists Affirming Their Gay, Lesbian, and Bisexual Family—supports clinical and research work on LGB issues within psychology and encourages sensitivity to the role of sexual orientation in all clinical and research work. Interested readers can learn more about AFFIRM at [www.sunysb.edu/affirm](http://www.sunysb.edu/affirm).

Deciding whether and with whom to share their sexual orientation are both complex issues that nearly all LGB individuals face. Research offers contradictory evidence regarding the psychological benefits of coming out (D'Augelli & Hershberger, 1993; Green, 2000; Savin Williams, 1998). It is currently unclear whether disclosure to one's parents, for instance, leads to poorer mental health, leads to better mental health, or is irrelevant to mental health. Clearly, it is important to assess the multifarious contexts in which the decision to come out is made. Strommen (1993) suggested three issues that are useful for therapists to consider in working with LGB clients who are influenced by family of origin concerns: (a) the family's values concerning sexual orientation, (b) the effect of those values on the relationship between disclosing family member and the family member who receives the news, and (c) the conflict resolution mechanisms available to family members. Further, Collins and Zimmerman (1983) noted that the religious values of family members are most important in deciding whether to tell. As mentioned earlier, LGB individuals may need to be advised to first test the waters by telling their sexual orientation to a sibling, grandparent, or other family member who is perceived to be most accepting. However, LGB clients need to be cautioned that telling only one family member places a large responsibility on that person who must maintain such a secret.

In working with LGB clients who have not come out to family members, we need to recognize the strategies that LGB individuals employ in order to cope with the cognitive dissonance that may exist between their *closeted* family life and their *out* "extrafamily" life. These strategies may include avoidance of family members and family functions, becoming independent of family, and only disclosing their sexual orientation to those family members who



will enable the LGB individual's pretense of heterosexuality (Brown, 1988; Herdt & Boxer, 1993; Savin-Williams, 1998).

It is important to note that parents are not necessarily the first family members to whom LGB relatives disclose their sexual orientation. In fact, drawing from interviews with LGB adolescents, Savin-Williams (1998) noted that parents are *seldom* the first people whom LGB individuals tell. Siblings are usually told before parents (DeVine, 1984), but little research exists on sibling reactions to learning that a brother or sister is LGB. Further, there is a complete lack of data regarding disclosure to grandparents, but it can be expected that intergenerational issues may need to be considered, as grandparents may operate out of past social norms that strongly condemned homosexuality (Strommen, 1993).

Recent research has examined feelings of inclusion and belonging in LGB individuals attending family rituals. Oswald (2002) noted that the structure of many families (both those with and without LGB members) is increasingly changing. As family membership is becoming more complex, deciding whom to invite to a family function can become the basis for exclusion or inclusion within that family. Rituals can bring up issues of belonging and family membership long after coming out to them has occurred, and a particularly important factor is whether or not an LGB individual's partner is invited to attend a family function. Family events may challenge the legitimacy of a client's sexual orientation that up to that point may have seemed quite well established. Indeed, clients may report feeling as if they have been set back a few years in their sexual identity formation after visiting with family members whom they have not seen in a while. For instance, a lesbian student who has spent time away from home while at college and has established a network of accepting friends while away may be disappointed that this newly found support does not yet exist in her family as well.

Many LGB individuals supplement family of origin ties by creating chosen families. Laird (1998) described families of choice as "the families [that LGB individuals] have created outside of legal marriage that may include a partner, adopted or biological children, and/or an extended network of friends, usually but not exclusively lesbian and gay, who perform functions similar to those of close, extended biological families" (p. 198). Nardi and Sherrod (1994) extended this definition to include *past* romantic or sexual partners. In fact, it is widely noted that LGB women and men often include past romantic or sexual partners as close friends more commonly than do heterosexual individuals (Becker, 1988; Nardi & Sherrod, 1994; Slater, 1995).

Such extended networks of friends are often essential for LGB individuals for the following reasons: (a) families of origin may not be accepting of LGB relatives, (b) families of origin are composed mostly (if not entirely) of heterosexual members who are most likely not familiar with the strategies needed for successful living in a homophobic world, and (c) families of choice provide LGB role models who are able to affirm the fact that LGB individuals can live successful, fulfilling lives (Dalheimer & Feigal, 1994; D'Augelli & Garnets, 1995; Matthews & Lease, 2000; Weinstock & Rothblum, 1996).

Kurdeck and Schmidt's (1987) research regarding the importance of friends in the lives of same-sex couples found that gay men and lesbian women indicated that their friends served as primary sources of support somewhat more than partners and much more than family members and coworkers. There was also a

positive relationship between support from friends and partners and psychological adjustment, whereas this positive correlation did not hold for support from family and psychological adjustment.

It also needs to be noted, however, that parental and family support does play a crucial role in the psychological well-being of LGB individuals. Hershberger and D'Augelli (1995) found that the relationship between victimization and mental health in a sample of LGB adolescents is partially mediated by level of family support. They noted that family support leads to higher levels of self-acceptance, which in turn lead to more positive mental health. Their findings make it clear that family support is a primary mechanism for fostering self-esteem and self-respect for one's LGB orientation. They conclude that a sense of personal worth coupled with positive regard for one's sexual orientation appears to be essential for LGB adolescents' mental health. Similarly, Savin-Williams (1989) found that young gay men who were out to their mothers and had a satisfying relationship with their fathers were more likely to report high levels of self-esteem. In general, it may be said that the reactions of family members to a relative's disclosure of an LGB orientation can serve to either exacerbate or alleviate the distress associated with the coming-out process.

## Other Relevant Issues

There is clearly greater complexity surrounding sexual minority individuals than what has heretofore been mentioned in this article. Unique issues arise for older individuals, religious individuals, ethnic minorities, and bisexual individuals. Also, LGB individuals face substantial legal issues as well as issues in the workplace with which therapists ought to acquaint themselves.

For *aging LGB individuals*, the effects of homophobia and discrimination against sexual minorities are confounded with "ageism." Such ageism is heightened by stereotypes specifically targeting older gay men and lesbian women. For instance, older gay men are often viewed as increasingly effeminate, isolated, bitter, "dirty old men" who prey on young boys to satiate their sexual needs. Older lesbian individuals may be seen as grouchy, cold, masculine, and frustrated by the rejections of younger women (Berger & Kelly, 1996). Although there is a dearth of research in this area, the research that does exist refutes these notions and further suggests that gay men and lesbian women draw on their unique experiences as sexual minorities to successfully adapt to old age.

Several studies have examined the notion of accelerated aging in LGB groups. Accelerated aging is defined as experiencing oneself as old at an earlier age than would be suggested by one's chronological age (Friend, 1987). Gay male norms may contribute to increased feelings that one is beyond his prime well ahead of the age when his heterosexual peers define themselves as such (Bartun & Cramer, 2000). Friend (1980, 1987) reported that gay men defined themselves as old at an average age of 48, whereas a sample of the general population reported a mean age of 65 for defining themselves as old. Accelerated aging may explain the findings of Harry (1982) that gay men manifested more anxiety than heterosexual men toward growing old, especially if they were unpartnered. The standards of youth and beauty held by many gay men, as well as the deaths of friends and loved ones from AIDS, may additionally illuminate these findings. For many older gay men, the tenuousness of life is made salient by the disproportionate



loss of acquaintances and partners from AIDS experienced in gay male communities. It has been suggested that because lesbian women are less likely to attribute attractiveness to youth and often challenge rigid gender roles, they may be less prone to the accelerated aging that many gay men experience (Ritter & Terndrup, 2002).

There are a number of things to keep in mind when working with older LGB individuals. Participation in collective gay male activities and having previously come out successfully are both related to psychological adjustment in older gay men (Berger, 1984). Frost (1997) suggested that group therapy with older gay men is ideal for these reasons. As many LGB individuals learned how to cope with a stigmatized identity earlier in life (Friend, 1987), it would be helpful to encourage clients to apply the strengths that they have gained from other LGB-related stressors to their present circumstances. Further, we need to remember that our LGB clients often do not have support from family, either because of familial homophobia or the absence of children to support them as they age. Yet, it has been argued that for some individuals, such a lack of family support may enhance LGB individuals' self-sufficiency in older age (Kimmel, 1978).

Many LGB individuals face substantial discrimination by institutions charged with the care of sick or older individuals (Barün & Cramer, 2000). Social service agencies are often blind to the needs of LGB people. Also, hospital units, such as intensive care, usually deny visits to hospitalized individuals by all but blood relatives and spouses. Thus, hospitalized LGB individuals may have difficulty gaining permission to spend critical time with their partners and may need to take an assertive stance in preventing such denial of visitation. Further, LGB clients should be aided in considering alternatives to heterocentric nursing homes, as LGB individuals may encounter hostile or neglectful reactions from the staff of such institutions if their sexual orientation is disclosed. Older LGB individuals may also feel compelled to hide the sexual orientation that they have spent many years affirming. Resources such as Senior Action in a Gay Environment (SAGE) can assist LGB clients and their therapists in finding available services for older LGB individuals (www.sage.org).

It is also important for therapists to consider the unique issues that *religious LGB individuals* may bring to therapy. Many religious denominations continue to condemn homosexuality. Further, many antigay organizations (e.g., Exodus International, Focus on the Family) align themselves with religious doctrine supposedly condemning homosexuality. Thus, it is likely that religious LGB individuals seek conversion therapies at higher rates than nonreligious individuals. In their study, Schuck and Liddle (2001) found that their LGB participants often experienced conflict between their sexual orientation and religion. These sources of conflict included scriptural passages, denominational teachings, and congregational prejudice. Haldeman (2002) has argued that the psychological impact that anti-LGB religious doctrine can have on LGB persons can be particularly devastating and offers a discussion of the ethical concerns that we as therapists ought to consider when working with religious LGB clients.

Resolutions that LGB individuals may employ include identifying themselves as spiritual rather than religious, reinterpreting religious teachings, changing affiliations, remaining religious but not attending religious services, abandoning religion altogether, and seeking sexual orientation conversion therapy (Schuck &

Liddle, 2001). LGB men and women have gone to great lengths to receive support from religious organizations. Many have chosen to create their own denomination (e.g., the Metropolitan Community Church), while others have devoted efforts to forming organizations within existing denominations (e.g., Dignity USA for Catholic LGB individuals, the World Congress of Gay and Lesbian Jewish Organizations, and Affirmation for Mormon LGB individuals).

LGB individuals who are also members of an *ethnic or racial minority* group may be at an increased risk for experiencing stress. Such stress may arise from the individual effects of racial prejudice and societal discrimination against sexual minorities as well as the complex interaction of the two. Though ethnic minority LGB individuals may encounter many issues not experienced by White LGB individuals, the psychological literature addressing these issues is sparse. Still, we as therapists need to consider such things as the family values and the spiritual, gender, and sexual values of the ethnic group that may have important implications for how an ethnic minority client handles his or her sexual orientation. We also need to consider the history of the client's ethnic group, especially in relationship to the dominant group, as well as the extent of the client's assimilation. Although there is a wide variation within and across ethnic groups, it is nonetheless useful to consider some of the common experiences across ethnic minority LGB individuals in order to gain a broad understanding of the types of issues that ethnic LGB clients may confront.

Ethnic minority LGB individuals must not only confront the dominant culture's racism, sexism, and heterocentrism but must also deal with their own ethnic group's sexism, heterocentrism, and internalized racism (Greene, 1994). These individuals may conceptualize coming out as a complicated choice between their ethnic group's support and their LGB group's support. For instance, one option is to keep one's LGB identity hidden from one's community in order to avoid jeopardizing the support that the community offers in other domains. For instance, Black communities often serve as "necessary protective barrier[s] and survival tool[s] against the racism of the dominant culture" (Greene, 1994, p. 245). A Black gay man, for instance, may not wish to compromise such support from his primary Black community. It has been observed that some African American men prefer to describe themselves as "men who have sex with men" or as "being on the down low" rather than "gay," possibly because of the potential threat to the support of their ethnic community (King, 2004). The other option is to neglect the importance of one's ethnic community in favor of identifying as an LGB individual. However, LGB individuals may face discrimination from LGB communities in their locale if these communities hold the same prejudices and biases of the dominant culture.

Many cultures do not stigmatize same-sex sexual behavior and attraction. As an example, many Native American tribes historically treated individuals who exhibited cross-gender behavior and a same-sex sexual preference as *special* and, further, gave such individuals a special status in the tribe. It is important, however, not to assume that all Native American LGB clients have encountered such reverence from their group. Other factors need to be considered, such as assimilation, that determine the degree to which one's group still holds the traditional values of that group.

The notion of LGB sexualities for some ethnic groups is often a threat to the groups' notions of gender and family. For instance,

many Latin American individuals possess strict notions of gender and sex roles. Women in these cultures are often discouraged from exploring their sexualities, whereas men are supposed to be sexually experienced. Thus, because of the structure of their society, Latin American women are often emotionally and physically close to other women without being seen as lesbian women (Greene, 1994). Also, it is not uncommon for Latino men to have sex with other men. The man who assumes an active role is not seen as gay, whereas the passive (or receiving) male *is* seen as such. Asian American individuals often conceptualize sexuality as something very private. Similar to Latin American women, Asian American women are often assumed to be sexually naïve. Thus, an Asian American woman's proclamation of an LGB identity may be seen as a challenge to the group's notions of the proper role of women.

Many groups see homosexuality as a White construct—something that was unknown to their group until Europeans or Americans introduced it to them either through colonization or acculturation. It is thus particularly important to be aware that many cultures reject LGB sexualities more than the dominant culture. Indeed, these groups often do so by denying the very existence of non-heterosexual sexualities in members of their group. Greene (1994) offered an excellent review of specific issues faced by many ethnic minority groups as well as issues that therapists should consider when working with ethnic minority LGB individuals in therapy.

Also, we need to be aware of the issues that *bisexual* individuals face. For instance, it is possible that developmental models designed to describe the experiences of gay men and lesbian women may not necessarily be applicable to bisexual individuals. Moreover, when coming out, bisexual individuals may not have a readily identifiable community as a resource and may therefore feel constrained to identify with either gay or lesbian communities that, unfortunately, often express biphobia. This may lead to bisexual individuals feeling invisible and, consequently, suppressing their bisexual identities (Dworkin, 2001). To further complicate matters, heterosexual, gay, and lesbian individuals often possess stereotypical notions of bisexuality, including the idea that bisexuality is a transitional identity occurring temporally between heterosexual and homosexual identities and that it is a denial of true homosexual leanings. These stereotypes may hamper bisexual individuals' efforts at accepting their bisexuality as a valid identity.

Relationships involving one or more bisexual individuals are often overlooked in the literature. There are a few findings, though, that can be useful when working clinically with bisexual individuals who are in relationships. Reinhardt (2002) suggested on the basis of her findings from 26 bisexual women that bisexual individuals may desire more than one partner. Because their partners often cannot handle the bisexual individual's need for nonmonogamy, it has been suggested that bisexual individuals' relationships tend to be less stable than the relationships of either homosexual or heterosexual individuals (Weinberg, Williams, & Pryor, 1994). Matteson (1996) and Rust (2003) offered some implications for working with couples in which one partner is bisexual.

Also relevant are the clinical implications of the *legal issues* that LGB clients face. Such issues often involve the legitimacy of LGB partnerships and LGB individuals' roles as parents. Other issues include immigration issues for same-sex partners, legally sanc-

tioned blocks of partner visits in hospitals, and child custody issues.

LGB individuals have made impressive strides in achieving legal recognition of their partnerships: Employers have begun to provide domestic partner health benefits for their LGB employees; nationwide sodomy laws have been invalidated; and the legality of traditional, heterocentric definitions of marriage have been increasingly called into question. Still, LGB individuals and relationships continue to face discrimination. For instance, although partners of heterosexual Americans can gain permanent resident status and eventual citizenship through marriage, immigration laws do not recognize same-sex couples. In fact, under no circumstance can a U.S. citizen use a same-sex relationship as a basis for sponsoring a partner from a foreign country, no matter how long the couple has been together nor how committed their relationship is. Also, as noted earlier, hospital policies often allow only spouses or blood relatives to visit intensive care units, such that the partners of LGB patients are frequently denied access to their loved ones in times of severe emotional crises. Our clients need to be foresighted by preparing the execution of medical powers of attorney and wills. The fact that child custody issues are decided by judges, not juries, and thus are difficult to get reversed may also pose substantial challenges to LGB individuals involved in such legal processes (Rivera, 1991). In such cases, judges may rely on inaccurate stereotypes and give undue weight to the parent's sexual orientation (Falk, 1989).

Finally, given the substantial amount of time that most individuals spend in the workplace, we need to be mindful of the issues facing our LGB clients in their *work environments*. LGB clients need to consider whether or not to come out at work. To be sure, certain occupations have traditionally been more accepting of LGB employees. Still, as therapists, we need to consider the impact that workplace heterocentrism and homophobia can have on our LGB clients' career development. Schneider (1986) examined the influence of workplace environment on lesbian women's decisions to disclose their sexual orientation. She found that more lesbian women chose to disclose their sexual orientation when they worked in smaller settings, human service occupations, and female dominated-workplaces and when their incomes were lower. Ros-tosky and Riggle (2002) found that the presence of a workplace nondiscrimination policy was positively associated with the extent to which an individual was out at work.

Ragins and Cornwell (2001) tested a model of the antecedents of gay and lesbian individuals' perceptions of workplace discrimination. They found that the existence of LGB-affirming organizational policies and practices had a greater effect on perceived workplace discrimination than did the number of gay or lesbian coworkers or the existence of an LGB supervisor. Ragins and Cornwell also found that the policy or practice that had the greatest impact on perceptions of discrimination and the decision to disclose was the invitation of same-sex partners to company social events. This suggests that we may need to encourage our LGB clients to seek workplaces that have accepting policies and practices regarding LGB employees, such as domestic partner benefits and written policies prohibiting sexual orientation discrimination.

In order to facilitate an understanding of the unique experiences of LGB individuals at work, therapists may wish to consult Woods' (1994) examination of the results of hundreds of interviews with gay men and the various strategies that they developed

for managing their sexual identity at work. Further, LGB therapists who are considering coming out in their own work environs are referred to DeCrescenzo's (1997) edited volume exploring the topic.

## Concluding Comments

The gains that LGB individuals have made in the past few decades are remarkable. It is a testament to the strength of this group that they have persisted in the face of monumental challenges. There is no reason to believe that LGB individuals will not make equally substantial changes in the decades to come. Indeed, LGB individuals are constantly making admirable attempts to gain equality with their heterosexual peers. However, as therapists, we must not forget that our profession has historically condemned—and that some professionals continue to condemn—sexual minorities. As a result, we need to demonstrate that we possess the competence required to treat LGB individuals appropriately. Such ability is gained by familiarizing ourselves with the appropriate guidelines and recommendations as well as the existing literature on specific issues that are relevant to our LGB clients.

Social progress is changing the experiences of LGB individuals. It is important to remember that what was true for LGB individuals at one point in time will not necessarily be true at another point in time. For example, during the 1990s, greater percentages of youth began coming out to their parents (Savin-Williams, 1998), no doubt as a result of the larger social movement involving public discourse on homosexuality. Fox (1993) found that the coming-out process may also be occurring earlier for younger bisexual individuals. Clearly, the experiences of an LGB individual who came out 40 years ago is much different from the experiences of an LGB individual who is coming out today.

LGB individuals present unique issues to therapists. When we incorporate an understanding of these issues into our therapeutic work with LGB clients, we increase the likelihood that our work will lighten the impact that societal homophobia and discrimination has had on these individuals. LGB issues also have the potential to inform our work with heterosexual individuals. For instance, Goldfried (2001) discussed the insights that “mainstream” psychology can gain by focusing on such issues as LGB identity development, LGB close relationships, and families of choice, to name a few. Thus, possessing an awareness of the unique issues that LGB individuals bring to therapy not only decreases the negative effects of homophobia and heterocentrism on our LGB clients but also has the potential to increase our comprehensive understanding of human behavior.

## References

- American Association of University Women. (1993). *Hostile hallways*. Washington, DC: Author.
- American Psychological Association. (1997). *Resolution on appropriate therapeutic responses to sexual orientation*. Washington, DC: Author.
- American Psychological Association. (2000). Guidelines for psychotherapy with lesbian, gay, and bisexual clients [Electronic version]. *American Psychologist*, 55, 1440–1451.
- Anderson, D. (1987). Family and peer relations of gay adolescents. *Adolescent Psychiatry*, 14, 162–178.
- Anhalt, K., Morris, T. L., Scotti, J. R., & Cohen, S. H. (2003). Student perspectives on training in gay, lesbian, and bisexual issues: A survey of behavioral clinical psychology programs. *Cognitive and Behavioral Practice*, 10, 255–263.
- Bailey, J. M., Nothnagel, J., & Wolfe, M. (1995). Retrospectively measured individual differences in childhood sex-typed behavior among gay men: Correspondence between self- and maternal-reports. *Archives of Sexual Behavior*, 24, 613–622.
- Barün, A., & Cramer, D. W. (2000). Potential counseling concerns of aging lesbian, gay, and bisexual clients. In R. M. Perez, K. A. DeBord, & K. J. Bieschke (Eds.), *Handbook of psychotherapy with lesbians, gay, and bisexual clients* (pp. 207–223). Washington, DC: American Psychological Association.
- Becker, C. S. (1988). *Unbroken ties: Lesbian ex-lovers*. Boston: Alyson.
- Bell, A. P., & Weinberg, M. S. (1978). *Homosexualities: A study of diversity among women and men*. New York: Simon & Schuster.
- Bell, A. P., Weinberg, M. S., & Hammersmith, S. K. (1981). *Sexual preference: Its development in women and men*. Bloomington, IN: Indiana University Press.
- Berger, R. M. (1984). Realities of lesbian and gay aging. *Social Work*, 23, 57–62.
- Berger, R. M., & Kelly, J. J. (1996). Gay men and lesbians grown older. In R. P. Cabaj & T. S. Stein (Eds.), *Textbook of homosexuality and mental health* (pp. 305–316). Washington, DC: American Psychiatric Press.
- Bigner, J. J. (1996). Working with gay fathers: Development, postdivorce parenting, and therapeutic issues. In J. Laird & R. J. Green (Eds.), *Lesbian and gay couples and families: A handbook for therapists* (pp. 370–403). San Francisco: Jossey-Bass.
- Blumstein, P., & Schwartz, P. (1983). *American couples: Money, work, and sex*. New York: Morrow.
- Brown, L. S. (1988). Lesbians, gay men, and their families: Common clinical issues. *Journal of Gay & Lesbian Psychotherapy*, 1, 65–77.
- Brown, L. S. (1989). Lesbians, gay men, and their families: Common clinical issues. *Journal of Lesbian and Gay Psychotherapy*, 1, 65–77.
- Brown, L. S. (1996). Ethical concerns with sexual minority patients. In R. P. Cabaj & T. S. Stein (Eds.), *Textbook of homosexuality and mental health* (pp. 897–916). Washington, DC: American Psychiatric Press.
- Brown, L. S. (2000). Foreword. In R. M. Perez, K. A. DeBord, & K. J. Bieschke (Eds.), *Handbook of counseling and psychotherapy with lesbians, gay, and bisexual clients* (pp. xi–xiii). Washington, DC: American Psychological Association.
- Burch, B. (1986). Psychotherapy and the dynamics of merger in lesbian couples. In T. S. Stein & C. J. Cohen (Eds.), *Contemporary perspectives on psychotherapy with lesbians and gay men* (pp. 57–102). New York: Plenum.
- Buxton, A. P. (2001). Writing our own script: How bisexual men and their heterosexual wives maintain their marriages after disclosure. *Journal of Bisexuality*, 1, 155–189.
- Cass, V. C. (1979). Homosexual identity formation: A theoretical model. *Journal of Homosexuality*, 4, 219–235.
- Clark, D. (1987). *The new loving someone gay*. Berkeley, CA: Celestial Arts.
- Coleman, E. (1981/1982). Developmental stages of the coming out process. *Journal of Homosexuality*, 7, 31–43.
- Collins, L. E., & Zimmermann, N. (1983). Homosexual and bisexual issues. *Family Therapy Collections*, 5, 82–100.
- Comstock, G. D. (1991). *Violence against lesbians and gay men*. New York: Columbia University Press.
- Cornett, C. (1993). *Affirmative dynamic psychotherapy with gay men*. Northvale, NJ: Aronson.
- Crosbie-Burnett, M., Foster, T. L., Murray, C. I., & Bowen, G. L. (1996). Gay's and lesbians' families-of-origin: A social-cognitive-behavioral model of adjustment. *Family Relations: Journal of Applied Family & Child Studies*, 45, 397–403.
- Dahlheimer, D., & Feigal, J. (1994). Community as family: The multiple-family contexts of gay and lesbian clients. In C. H. Huber (Ed.),



- Transitioning from individual to family counseling* (pp. 63–74). Alexandria, VA: American Counseling Association.
- D'Augelli, A. R. (1992). Lesbian and gay undergraduates' experiences of harassment and fear on campus. *Journal of Interpersonal Violence*, 7, 383–395.
- D'Augelli, A. R., & Garnets, L. D. (1995). Lesbian, gay, and bisexual communities. In A. R. D'Augelli & C. J. Patterson (Eds.), *Lesbian, gay, and bisexual identities over the lifespan: Psychological perspectives* (pp. 293–320). New York: Oxford University Press.
- D'Augelli, A. R., & Hershberger, S. L. (1993). Lesbian, gay, and bisexual youth in community settings: Personal challenges and mental health problems. *American Journal of Community Psychology*, 21, 421–448.
- D'Augelli, A. R., & Patterson, C. J. (2001). *Lesbian, gay, and bisexual identities and youth: Psychological perspectives*. New York: Oxford University Press.
- Davies, D. (1996). Towards a model of gay affirmative therapy. In D. Davies & C. Neal (Eds.), *Pink therapy: A guide for counselors and therapists working with lesbian, gay, and bisexual clients* (pp. 24–40). Buckingham, England: Open University Press.
- Davies, D., & Neal, C. (1996). *Pink therapy: A guide for counselors and therapists working with lesbian, gay, and bisexual clients*. Buckingham, England: Open University Press.
- Decrescenzo, T. (1997). *Gay and lesbian professionals in the closet: Who's in, who's out, and why*. New York: Harrington.
- Devine, J. L. (1984). A systemic inspection of affectional preference orientation and the family of origin. *Journal of Social Work and Human Sexuality*, 2, 9–17.
- Diamond, L. (1998). Development of sexual orientation among adolescent and young adult women. *Developmental Psychology*, 34, 1085–1095.
- Diamond, L. (2000). Sexual identity, attractions, and behavior among young sexual minority women over a 2-year period. *Developmental Psychology*, 36, 241–250.
- Diamond, L. (2003). Was it a phase? Young women's relinquishment of lesbian/bisexual identities over a 5-year period. *Journal of Personality and Social Psychology*, 84, 352–364.
- Dunne, M. P., Bailey, J. M., Kirk, K. M., & Martin, N. G. (2000). The subtlety of sex-atypicality. *Archives of Sexual Behavior*, 29, 549–564.
- Dworkin, S. H. (2000). Individual therapy with lesbian, gay, and bisexual clients. In R. M. Perez, K. A. DeBord, & K. J. Bieschke (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, and bisexual clients* (pp. 157–181). Washington, DC: American Psychological Association.
- Dworkin, S. H. (2001). Treating the bisexual client. *In Session: Journal of Clinical Psychology*, 57, 671–680.
- Falco, K. L. (1991). *Psychotherapy with lesbian clients: Theory into practice*. New York: Brunner/Mazel.
- Falco, K. L. (1996). Psychotherapy with women who love women. In R. P. Cabaj & T. S. Stein (Eds.), *Textbook of homosexuality and mental health* (pp. 397–412). Washington, DC: American Psychiatric Press.
- Falk, P. J. (1989). Lesbian mothers: Psychosocial assumptions in family law. *American Psychologist*, 44, 941–947.
- Fassinger, R. E. (1991). The hidden minority: Issues and challenges in working with lesbian women and gay men. *The Counseling Psychologist*, 19, 157–175.
- Fassinger, R. E. (2000). Applying counseling theories to lesbian, gay, and bisexual clients: Pitfalls and possibilities. In R. M. Perez, K. A. DeBord, & K. J. Bieschke (Eds.), *Handbook of psychotherapy with lesbians, gay, and bisexual clients* (pp. 107–131). Washington, DC: American Psychological Association.
- Fitzgerald, B. (1999). Children of lesbian and gay parents: A review of the literature. *Marriage and Family Review*, 29, 57–75.
- Fox, R. C. (1993). Coming out bisexual: Identity, behavior, and sexual orientation self-disclosure. Unpublished doctoral dissertation, California Institute of Integral Studies, San Francisco.
- Frale, D. E. S., Wortman, C., & Joseph, J. (1997). Predicting self-esteem, well-being, and distress in a cohort of gay men: The importance of cultural stigma, personal visibility, community networks, and positive identity. *Journal of Personality*, 65, 599–624.
- Friend, R. A. (1980). GAYging: Adjustment and the older gay male. *Alternative Lifestyles*, 3, 231–248.
- Friend, R. A. (1987). The individual and social psychology and again: Clinical implications for lesbians and gay men. *Journal of Homosexuality*, 14, 301–331.
- Frost, J. C. (1997). Group psychotherapy with the aging gay male: Treatment of choice. *Group*, 21, 267–285.
- Garnets, L., Hancock, K. A., Cochran, S. D., Goodchilds, J., & Peplau, L. A. (1991). Issues in psychotherapy with lesbians and gay men. *American Psychologist*, 46, 964–972.
- Garnets, L. D., & Kimmel, D. C. (1993). Introduction: Lesbian and gay male dimensions in the psychological study. In L. D. Garnets & D. C. Kimmel (Eds.), *Psychological perspectives on lesbian and gay male psychology* (pp. 1–51). New York: Columbia University Press.
- Gartrell, N. K. (1994). Boundaries in lesbian therapist/client relationships. In B. Greene & G. M. Herek (Eds.), *Lesbian and gay psychology: Theory, research, and clinical applications* (p. 98–117). Thousand Oaks, CA: Sage.
- Gelso, C. J., Fassinger, R. E., Gomez, M. J., & Latts, M. G. (1995). Countertransference reactions to lesbian clients: The role of homophobia, counselor gender, and countertransference management. *Journal of Counseling Psychology*, 42, 356–364.
- Goldfried, M. R. (2001). Integrating lesbian, gay, and bisexual issues into mainstream psychology. *American Psychologist*, 56, 977–988.
- Goldfried, M. R., & Goldfried, A. P. (2001). The importance of parental support in the lives of lesbian, gay, and bisexual individuals. *In Session: Journal of Clinical Psychology*, 57, 681–693.
- Gonsiorek, J. C. (1988). Mental health issues of lesbian and gay adolescents. *Journal of Adolescent Health*, 9, 114–122.
- Gonsiorek, J. C., & Rudolph, J. R. (1991). Homosexual identity: Coming out and other developmental events. In J. C. Gonsiorek & J. R. Weinrich (Eds.), *Sexuality/research implications for public policy* (pp. 161–176). Newbury Park, CA: Sage.
- Gottman, J. M., Levenson, R. W., Gross, J., Fredrickson, B. L., McCoy, K., Rosenthal, L., et al. (2003). Correlates of gay and lesbian couples' relationship satisfaction and relationship dissolution. *Journal of Homosexuality*, 45, 23–44.
- Grace, J. (1992). Affirming lesbian and gay adulthood. In N. J. Woodman (Ed.), *Lesbian and gay lifestyles: A guide for counseling and education* (pp. 33–47). New York: Irvington.
- Green, R.-J. (1978). Sexual identity of 37 children raised by homosexual or transsexual parents. *American Journal of Psychiatry*, 135, 692–697.
- Green, R.-J. (2000). "Lesbians, gay men, and their parents": A critique of LaSala and the prevailing clinical "wisdom." *Family Process*, 39, 257–266.
- Green, R.-J., Bettinger, M., & Zacks, E. (1996). Are lesbian couples fused and gay male couples disengaged? In J. Laird & R. J. Green (Eds.), *Lesbian and gays in couples and families* (pp. 185–230). San Francisco: Jossey Bass.
- Green, R.-J., Mandel, J. B., Hotvedt, M. E., Gray, J., & Smith, L. (1986). Lesbian mothers and their children: A comparison with solo parent heterosexual mothers and their children. *Archives of Sexual Behavior*, 15, 167–184.
- Green, R.-J., & Mitchell, V. (2002). Lesbian and gay couples in therapy: Homophobia, relational ambiguity, and social support. In A. S. Gurman & N. S. Jacobson (Eds.), *Clinical handbook of couple therapy* (pp. 546–568). New York: Guilford Press.
- Greenan, D. E., & Tunnell, G. (2003). *Couple therapy with gay men*. New York: Guilford Press.
- Greene, B. (1994). Ethnic-minority lesbians and gay men: Mental health

- and treatment issues. *Journal of Consulting and Clinical Psychology*, 62, 243–251.
- Haldeman, D. C. (2002). Gay rights, patient rights: The implications of sexual orientation conversion therapy. *Professional Psychology: Research and Practice*, 33, 260–264.
- Harry, J. (1982). Decision making and age differences among gay male couples. *Journal of Homosexuality*, 8, 9–22.
- Hayes, J. A., & Gelso, C. J. (1993). Male counselors' discomfort with gay and HIV-infected clients. *Journal of Counseling Psychology*, 40, 86–93.
- Herd, G. M. (1989). *Lesbian and gay youth*. New York: Harrington Park Press.
- Herd, G., & Boxer, A. (1993). *Children of horizons: How lesbian and gay teens are leading a new way out of the closet*. Boston: Beacon Press.
- Herek, G. M. (1991). Stigma, prejudice, and violence against lesbians and gay men. In J. Gonsiorek & J. R. Rudolph (Eds.), *Homosexuality: Research implications for public policy* (pp. 60–80). Newbury Park, CA: Sage.
- Herek, G. M. (1996a). Heterosexism and homophobia. In R. P. Cabaj & T. S. Stein (Eds.), *Textbook of homosexuality and mental health* (pp. 101–113). Washington, DC: American Psychiatric Press.
- Herek, G. M. (1996b). Why tell if you're not asked? Selfdisclosure, intergroup contact, and heterosexuals' attitudes toward lesbians and gay men. In J. B. Jobe (Ed.), *Out in force: Sexual orientation and the military* (pp. 197–225). Chicago: University of Chicago Press.
- Herek, G. M., & Capitanio, J. P. (1996). "Some of my best friends": Intergroup contact, concealable stigma, and heterosexuals' attitudes toward gay men and lesbians. *Personality and Social Psychology Bulletin*, 22, 412–424.
- Herek, G. M., Cogan, J. C., & Gillis, J. R. (2002). Victim experiences in hate crimes based on sexual orientation. *Journal of Social Issues*, 58, 319–339.
- Hershberger, S. L., & D'augelli, A. R. (1995). The impact of victimization on the mental health and suicidality of lesbian, gay, and bisexual youths. *Developmental Psychology*, 31, 65–74.
- Hershberger, S. L., & D'augelli, A. R. (2000). Issues in counseling lesbian, gay, and bisexual adolescents. In R. M. Perez, K. A. DeBord, & K. J. Bieschke (Eds.), *Handbook of psychotherapy with lesbians, gay, and bisexual clients* (pp. 207–223). Washington, DC: American Psychological Association.
- Higgins, D. J. (2002). Gay men from heterosexual marriages: Attitudes, behaviors, childhood experiences, and reasons for marriage. *Journal of Homosexuality*, 42, 15–34.
- Hughes, T. L., & Eliason, M. (2002). Substance use and abuse in lesbian, gay, bisexual, and transgender populations. *Journal of Primary Prevention*, 22, 263–298.
- Isay, R. (1989). *Being homosexual: Gay men and their development*. New York: Avon Books.
- Johnson, S. M., & O'Connor, E. (2001). *The gay baby boom: The psychology of gay parenthood*. New York: New York University Press.
- Johnson, S. M., & O'Connor, E. (2002). *For lesbian parents: Your guide to helping your family grow up happy, healthy, and proud*. New York: New York University Press.
- Kimmel, D. (1978). Adult development and aging: A gay perspective. *Journal of Social Issues*, 34, 113–130.
- King, J. L. (2004). *On the down low: A journey into the lives of "straight" Black men who sleep with men*. New York: Broadway Books.
- Kirkpatrick, M., Smith, C., & Roy, R. (1981). Lesbian mothers and their children: A comparative survey. *American Journal of Orthopsychiatry*, 51, 545–551.
- Kitzinger, C. (1987). *The social construction of lesbianism*. London: Sage.
- Kübler-ross, E. (1969). *On death and dying*. New York: MacMillan.
- Kurdek, L. A. (1988). Perceived social support in gays and lesbians in cohabiting relationships. *Journal of Personality & Social Psychology*, 54, 504–509.
- Kurdek, L. A. (1992). Relationship stability and relationship satisfaction in cohabiting gay and lesbian couples: A prospective longitudinal test of the contextual and interdependence models. *Journal of Social and Personal Relationships*, 9, 125–142.
- Kurdek, L. A., & Schmidt, J. P. (1987). Perceived support from family and friends in members of homosexual, married, and heterosexual cohabiting couples. *Journal of Homosexuality*, 14, 57–68.
- Laird, J. (1998). Invisible ties: Lesbians and their families of origin. In C. J. Patterson & A. R. D'Augelli (Eds.), *Lesbian, gay, and bisexual identities in families: Psychological perspectives* (pp. 197–228). New York: Oxford University Press.
- Liddle, B. J. (1996). Therapist sexual orientation, gender, and counseling practices as they relate to ratings on helpfulness by lesbian and gay clients. *Journal of Counseling Psychology*, 43, 394–401.
- Margolies, L., Becker, M., & Jackson-Brewer, K. (1987). Internalized homophobia and treating the oppressor within. In *Boston Lesbian Psychologies Collective* (Ed.), *Lesbian psychologies: Explorations and challenges* (pp. 229–241). Chicago: University of Illinois Press.
- Martin, A. P. (1982). Learning to hide: The socialization of the gay adolescent. *Adolescent Psychiatry*, 10, 52–65.
- Matteson, D. R. (1985). Bisexual men in marriage: Is a positive homosexual identity and stable marriage possible? *Journal of Homosexuality*, 11, 149–172.
- Matteson, D. R. (1996). Psychotherapy with bisexual individuals. In R. P. Cabaj & T. S. Stein (Eds.), *Textbook of homosexuality and mental health* (pp. 1433–1450). Washington, DC: American Psychiatric Press.
- Matthews, A. K., Hughes, T. L., Johnson, T., Razzano, L. A., & Cassidy, R. (2002). Prediction of depressive distress in a community sample of women: The role of sexual orientation. *American Journal of Public Health*, 92, 1131–1139.
- Matthews, C. R., & Lease, S. H. (2000). Focus on lesbian, gay, and bisexual families. In R. M. Perez, K. A. DeBord, & K. J. Bieschke (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, and bisexual clients* (pp. 249–273). Washington, DC: American Psychological Association.
- Mattison, A. M., & McWhirter, D. P. (1995). Lesbians, gay men, and their families: Some therapeutic issues. *Psychiatric Clinics of North America*, 18(1), 123–137.
- Morgan, K. S. (1992). Caucasian lesbians' use of psychotherapy: A matter of attitude? *Psychology of Women Quarterly*, 16, 127–130.
- Morrow, S. L. (2000). First do no harm: Therapist issues in psychotherapy with lesbian, gay, and bisexual clients. In R. M. Perez, K. A. DeBord, & K. J. Bieschke (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, and bisexual clients* (pp. 137–156). Washington, DC: American Psychological Association.
- Nardi, P. M., & Sherrod, D. (1994). Friendship in the lives of gay men and lesbians. *Journal of Social & Personal Relationships*, 11, 185–199.
- National Lesbian and Gay Health Foundation. (1988). *The national lesbian health care survey: Final report*. Washington, DC: Author.
- Nicolosi, J., & Nicolosi, L. A. (2002). *A parent's guide to preventing homosexuality*. Downers Grove, IL: Intervarsity Press.
- Oswald, R. F. (2002). Inclusion and belonging in the family rituals of lesbian and gay people. *Journal of Family Psychology*, 16, 428–436.
- Patterson, C. J. (1995). Lesbian mothers, gay fathers, and their children. In A. R. D'Augelli & C. J. Patterson (Eds.), *Lesbian, gay, and bisexual identities across the lifespan* (pp. 262–290). New York: Oxford University Press.
- Peplau, L. A. (1991). Lesbian and gay relationships. In J. C. Gonsiorek & J. D. Weinrich (Eds.), *Homosexuality: Research implications for public policy* (pp. 177–196). Newbury Park, CA: Sage.
- Peplau, L. A., & Cochran, S. D. (1981). Value orientations in the intimate relationships of gay men. *Journal of Homosexuality*, 6, 1–19.
- Phillips, G., & Over, R. (1992). Adult sexual orientation in relation to

- memories of childhood gender conforming and gender nonconforming behaviors. *Archives of Sexual Behavior*, 21, 543–558.
- Phillips, J. C., & Fischer, A. R. (1998). Graduate students' training experiences with lesbian, gay, and bisexual issues. *Counseling Psychologist*, 26, 712–734.
- Purcell, D. W., Campos, P. E., & Perilla, J. L. (1996). Therapy with lesbians and gay men: A cognitive behavioral approach. *Cognitive and Behavioral Practice*, 3, 391–415.
- Radkowsky, M., & Siegal, L. J. (1997). The gay adolescent: Stressors, adaptations, and psychosocial interventions. *Clinical Psychology Review*, 17, 191–216.
- Ragins, B. R., & Cornwell, J. M. (2001). Pink triangles: Antecedents and consequences of perceived workplace discrimination against gay and lesbian employees. *Journal of Applied Psychology*, 6, 1244–1261.
- Reinhardt, R. U. (2002). Bisexual women in heterosexual relationships. *Journal of Bisexuality*, 2, 163–171.
- Ritter, K. I., & Terndrup, A. I. (2002). *Handbook of affirmative psychotherapy with lesbians and gay men*. New York: Guilford Press.
- Rivera, R. R. (1991). Sexual orientation and the law. In J. C. Gonsiorek & J. D. Weinrich (Eds.), *Homosexuality: Research implications for public policy* (pp. 81–100). Newbury Park, CA: Sage.
- Rogers, C. R. (1951). *Client-centered counseling*. Boston: Houghton-Mifflin.
- Rostosky, S. S., & Riggle, E. D. B. (2002). "Out" at work: The relation of actor and partner workplace policy and internalized homophobia to disclosure status. *Journal of Counseling Psychology*, 4, 411–419.
- Rust, P. C. (2003). Monogamy and polyamory: Relationship issues for bisexuals. In L. D. Garnets & D. C. Kimmel (Eds.), *Psychological perspectives on lesbian, gay, and bisexual experiences* (pp. 497–548). New York: Columbia University Press.
- Safren, S. A., & Heimberg, R. G. (1999). Depression, hopelessness, suicidality, and related factors in sexual minority and heterosexual adolescents. *Journal of Consulting and Clinical Psychology*, 67, 859–866.
- Safren, S., & Rogers, T. (2001). Cognitive behavior therapy with lesbian, gay, and bisexual clients. *In Session: Journal of Clinical Psychology*, 57, 629–643.
- Savin-Williams, R. C. (1989). Coming out to parents and self-esteem among lesbian and gay youths. *Journal of Homosexuality*, 18, 1–35.
- Savin-Williams, R. C. (1998). Lesbian, gay and bisexual youths' relationships with their parents. In C. J. Patterson & A. R. D'Augelli (Eds.), *Lesbian, gay, and bisexual identities in families: Psychological perspectives* (pp. 75–98). New York: Oxford University Press.
- Savin-Williams, R. C. (2001). *"Mom, Dad, I'm gay": How families negotiate coming out*. Washington, DC: American Psychological Association.
- Schneider, B. (1986). Coming out at work: Bridging the private/public gap. *Work and Occupations*, 13, 463–487.
- Schuck, K. D., & Liddle, B. J. (2001). Religious conflicts experienced by lesbian, gay, and bisexual individuals. *Journal of Gay and Lesbian Psychotherapy*, 5, 63–82.
- Shannon, J. W., & Woods, W. J. (1991). Affirmative psychotherapy for gay men. *Counseling Psychologist*, 19, 197–215.
- Shields, S. A., & Harriman, R. E. (1984). Fear of male homosexuality: Cardiac responses of low and high homonegative males. *Journal of Homosexuality*, 10, 53–67.
- Slater, S. (1995). *The lesbian family life cycle*. New York: Free Press.
- Stein, T. S., & Cabaj, R. P. (1996). Psychotherapy with gay men. In R. P. Cabaj & T. S. Stein (Eds.), *Textbook of homosexuality and mental health* (pp. 413–432). Washington, DC: American Psychiatric Press.
- Strommen, E. F. (1993). "You're a what?": Family member reactions to the disclosure of homosexuality. In L. D. Garnets & D. C. Kimmel (Eds.), *Psychological perspectives on lesbian and gay male experiences* (pp. 248–266). New York: Columbia University Press.
- Troiden, R. R. (1979). Becoming homosexual: A model of gay identity acquisition. *Psychiatry*, 42, 362–373.
- Troiden, R. R. (1993). The formation of homosexual identities. In L. D. Garnets & D. C. Kimmel (Eds.), *Psychological perspectives on lesbian and gay male experiences* (pp. 191–217). New York: Columbia University Press.
- Weinberg, M. S., Williams, C. J., & Pryor, D. W. (1994). *Dual attraction: Understanding bisexuality*. New York: Oxford University Press.
- Weinstock, J. S., & Rothblum, E. D. (1996). What we can be together: Contemplating lesbians' friendships. In J. S. Weinstock & E. D. Rothblum (Eds.), *Lesbians and friendship: For ourselves and each other* (pp. 3–30). New York: New York University Press.
- Woods, J. D. (1994). *Corporate closet: The professional lives of gay men in America*. New York: Simon & Schuster.
- Yarhouse, M. A., Pawlowski, L. M., & Tan, E. S. (2003). Intact marriages in which one partner dis-identifies with experiences of same-sex attraction. *American Journal of Family Therapy*, 31, 375–394.